Claim for Survivor Benefits under Energy Employees Occupational Illness Compensation Program Act

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Provide all information requested below. **DO NOT FILL IN SHADED AREAS**.

OMB Number: 1215-0197
Expiration Date: 7/31/2004

SURVIVOR INFORMATION

1. Name *(Last, First, Middle Initial)*

2. Social Security Number

3. Date of Birth (Month Day Year)

4. Address *(Street, Apt #, P.O. Box)*

(City, State, ZIP Code)

5. Sex ☐ Male ☐ Female

6. Telephone Number ( ) –

7. What was your relationship to the deceased employee at the time of his/her death? (Spouse, child, parent, grandchild, grandparent)

DECEASED EMPLOYEE INFORMATION

8. Name *(Last, First, Middle Initial)*

9. Social Security Number (if known)

10. Sex ☐ Male ☐ Female

11. Date of Birth (Month Day Year)

12. Date of Death (Month Day Year)

13. Was an autopsy performed on the employee? ☐ YES List medical facility _____ ☐ NO

14. Identify Diagnosed Condition(s) Being Claimed

15. Date of Diagnosis (Month Day Year)

		Month	Day	Year
☐ Cancer *Specify Type(s)*:	a)			
	b)			
☐ Beryllium Sensitivity				
☐ Chronic Beryllium Disease				
☐ Chronic Silicosis				
☐ RECA Illness *Specify Type*:				

16. Identify Location or Type of Employment Performed by the Deceased Employee *(Mark any that apply)*:

☐ **Department of Energy Facility**
This is defined as any building, structure or premise in which the activities of federal employees, contractors or subcontractors have been conducted by or on behalf of the Department of Energy.

☐ **Atomic Weapons Facility**
This is defined as a privately-owned facility in which radioactive material has been processed for use by the United States in the manufacture of atomic weapons. (Excludes mining, milling, or transporting uranium ore.)

☐ **Beryllium Vendor**
This is defined as any privately operated entity engaged in producing or processing beryllium for sale or use by the Department of Energy.

☐ **Uranium Worker**
This is defined as employment activity associated with the mining, milling or transportation of uranium ore for use in the manufacture of atomic weapons.

SPECIAL EXPOSURE COHORT

17. Prior to February 1, 1992, did the deceased work at a gaseous diffusion plant in Paducah, Kentucky; Portsmouth, Ohio; or Oak Ridge, Tennessee?
☐ YES List site(s) _____ ☐ NO

18. Prior to January 1, 1974, did the deceased work at the Long Shot, Milrow, or Cannikin underground nuclear tests on Amchitka Island, Alaska?
☐ YES List site(s) _____ ☐ NO

19. Was the deceased a member of a group added to the Special Exposure Cohort by the Department of Health and Human Services?
☐ YES List group designation _____ ☐ NO ☐ DON'T KNOW

AWARDS AND OTHER INFORMATION

20. Have you or the deceased ever applied for an award under the Radiation Exposure Compensation Act?
☐ YES ☐ NO

21. Has a lawsuit seeking either money or medical coverage for the condition(s) being claimed on this form ever been filed?
☐ YES ☐ NO

22. Excluding any workers' compensation award, has a settlement or other award been granted in connection with the claimed condition(s)?
☐ YES ☐ NO

23. Have you either pled guilty or been convicted of any charges connected with an application for or receipt of federal or state workers' compensation?
☐ YES ☐ NO

OTHER POTENTIAL SURVIVORS

24. Are you aware of any other person who may qualify as a survivor of the deceased? (See instructions for survivor definition)

☐ YES ☐ NO

If yes, please provide the following:

	Name	Age	Relationship to deceased Employee	Address	Phone Number
a.					
b.					
c.					
d.					

SURVIVOR DECLARATION

25. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under the EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. Any change to the information provided on this form once submitted must be reported immediately to the District Office responsible for the administration of the claim.

I hereby make a claim for benefits under the Energy Employees Occupational Illness Compensation Program Act and affirm that the information I have provided on this form is true. Furthermore, I authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the United States Department of Labor, Office of Workers' Compensation Programs.

Claimant Signature _____ Date _____

PRIVACY ACT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 U.S.C. 7384 et seq.) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for, and the amount of, benefits payable under the EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities which employed the employee at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrativeoffset and debt collections actions required or permitted by the Debt Collection Act. (6) Disclosure of the claimant's social security number (SSN) or tax identification number (TIN) is mandatory. The SSN or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts by the Federal government, and for other purposes required or authorized by law.(7) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision. This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the EEOICPA.

PUBLIC BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 21 minutes per response, including time for reviewing instructions, searching existing data sources, gathering data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim to this address. Completed claims are to be submitted to the appropriate regional district Office of Workers' Compensation Programs. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.

BENEFITS FOR SURVIVORS UNDER ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) provides for a lump sum payment of $150,000 to eligible survivors of a covered employee who prior to the time of death had a designated illness incurred as a result of exposure to radiation, beryllium, or silica while in the performance of duty for the Department of Energy and certain of its vendors, contractors and subcontractors. This legislation also provides for a lump sum payment of $50,000 to certain survivors of deceased covered employee's, who were found eligible for compensation under the Radiation Exposure Compensation Act. (RECA).

DEFINITION OF SURVIVOR UNDER THE ACT

Entitlement to any lump sum payment for living survivor(s) of a deceased covered employee is determined at the time of payment. Under the EEOICPA, certain limitations apply to the definition of persons who may be eligible survivors. A lump sum payment will be paid to eligible survivors of the employee in the following order:

1. All to a surviving spouse
2. If no spouse, equal shares to all children
3. If no spouse or children,equal shares to the parents.
4. If no spouse, children or parents, equal shares to all grandchildren.

Any claim from a survivor must be accompanied by proof of relationship to the employee. This includes a copy of a marriage license, birth certificate, or adoption papers.

INSTRUCTIONS FOR COMPLETING FORM EE-2

Complete all items on the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. If the requested information is not submitted, the responsible party should explain the reason for the delay and indicate when the information will be forthcoming. Submit the completed claim form and all other pertinent documentation to the appropriate district office administering the EEOICPA in the region where the employee's most recent Energy employer is/was located.

Deceased Employee Information

Item #14 — Identify the condition related to employemnt the employee suffered prior to death. Attach to the claim form any pertinent medical documentation and a copy of the employee's death certificate. It is not necessary to establish death was caused by the claimed condition. Rather, the evidence must demonstrate a qualified physician diagnosed a covered condition prior to death.

Item #15 — List the date a qualified physician first diagnosed the claimed condition(s).

Item #16 — Mark location or type of work activities that best describe the deceased employee's work situation. If more than one of the listed categories applies, indicate such on the form. The Department of Energy has also compiled a list of covered facilities. This list is available at the Department of Energy's web site or by contacting the regional Division of Energy Employees Occupational Illness Compensation district office.

Special Exposure Cohort

Items #17–18 — The Act allows for employees who have met particular criteria and have been employed at certain facilities to be designated as members of the Special Exposure Cohort. If the deceased employee worked at any of the listed locations prior to the dates indicated, mark YES and identify the site name.

Item #19 — The Act permits the Department of Health and Human Services (HHS) to include new groups of employees in the Special Exposure Cohort. If you can identify the deceased employee as a member of a designated group that has been added to the Special Exposure Cohort, mark YES and describe the group in which he/she belonged.

Awards and Other Information

Item #20 — The EEOICPA provides for supplemental compensation to be paid to certain individuals who have applied to and received an award under RECA. You must indicate whether or not you or the deceased employee have ever applied for an award under RECA.

Item #21 — Indicate whether a lawsuit seeking money or medical coverage for the claimed condition(s) was ever filed. If you mark YES, provide copies of all court documentation.

Item #22 — You must identify whether any type of settlement or other award has been received in connection with the claimed condition(s). If you mark YES, provide copies of any relevant documentation.

Item #23 — Mark the appropriate box indicating whether or not you have ever pled guilty or been convicted of any charges connected to an application for or receipt of federal or state workers' compensation.

Other Potential Survivors

Item #24 — Every eligible survivor of a covered employee must be identified prior to the payment of compensation. If you are aware of any individual who meets the description of a survivor as described in these instructions, provide his/her name, age, relationship to deceased employee, address and phone number.